Report of the Ontario Council of Health on

Annex "A"

Regional Organization of Health Services

Ontario Department of Health
Honourable Thomas L. Wells, Minister

REGIONAL ORGANIZATION OF HEALTH SERVICES

ONTARIO

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JANUARY 1969

ONTARIO DEPARTMENT OF HEALTH
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FOREWORD

This report, prepared by the Committee on Regional Organization, was presented to the Ontario Council of Health in January, 1969. The report was approved by the Council, after certain amendments were made, with the agreement of the Chairman and Members of the Committee who were present at the Council meeting.

Readers are reminded that, while the Ontario Council of Health has endorsed the report as printed, it did so without formally attempting to co-ordinate the views and recommendations presented with those presented by other Committees of Council. In view of this, it is possible that Council could adopt a modified position when the influences of recommendations by other Committees are assessed.

The report covers the first phase of the work of this Committee of Council. It establishes that a system of regional organization, with two levels below Province, namely Region and District, offers the best method of providing the most effective total health service for the people of Ontario. A positive role for University Health Sciences Centres within the regions in Southern Ontario, and recognition of the need for special arrangements for those in Northern Ontario, are recommended. Included, also, are recommendations of principle concerning the establishment of councils at Region and District levels and the roles of the Provincial Government, Regional Councils and District Councils in a system of regional organization.

The Committee on Regional Organization is continuing with the second phase of the task it was assigned. It is currently carrying on investigations which will lead to recommendations concerned with the establishment and phasing of a system of regional organization of health services in Ontario. It is anticipated that the Committee will present a major report to Council in June 1970.

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Recommendations

RECOMMENDATIONS

The recommendations of this report are listed below to provide a quick guide for the reader. The Ontario Council of Health has approved the recommendations as presented.

1. THAT the organization and development of the several inter-related health services be carried out on the premise of providing the best possible total health services for the people of Ontario within a regional organization.

2. THAT such regional health organization should be based, in general and where specifically applicable, on university spheres of influence and interest and that every reasonable means be taken to assure that the health sciences centres of these universities are capable of assuming an active dual role in education and research, as is their prime function, as well as in continuing education, re-training and service consulting in both the professional and semi-professional aspects of the total health services with which they may be totally or in part responsible.

3. THAT the implementation of a regional plan for total health service be based on at least two levels of authority and responsibility, the region and districts within each region.

4. THAT councils be established at the regional and district levels to exercise the authority and responsibility delegated by the Province.

5. THAT the Province have the role of providing policy guidance, of setting standards and of assessing the overall effectiveness of the system.

6. THAT the regional council have the role, based on provincial guidelines, of planning for the provision of health services within its region, to ensure that efficient, effective and economic use is made of available manpower, facilities and funds.

7. THAT the district council have the role, based on provincial

guidelines and the regional planning programme, of organizing the provision of health care for the residents of the district, and of co-ordinating operational functions.

8. THAT a detailed study be made of methods of implementing a system of regional organization for Ontario.

Report of the Committee

SECTION I

Introduction

The Committee on Regional Organization of Health Services was given the following terms of reference by Council:

> *Regional organization should be studied not only in its effect on health services, but also its relationship to other planning. The Committee should study the regional organization proposed by the Department of Economics and Development so that the health pattern might be considered in the light of other arrangements.*

Early in the Committee's considerations, the desirability of establishing a system of regional organization of health services was accepted. This decision was based on the findings of the Royal Commission on Health Services, and on other studies related to the principles of regionalization. The results of studies made by the Committee on the concepts and purposes of regional organization, the involvement of the Provincial Government in regional organization to date, the existing patterns related to health care in Ontario, and some experience in regional health planning and organization in other countries, are summarized in the Background Paper attached as Appendix A.

Underlying all the deliberations of the Committee has been the principle that the system of regional organization developed should provide the most effective total health service for the people of Ontario. Specifically, the Committee has considered the role of the health sciences centres as the possible focal points for the regional

system, recognizing that special arrangements might be necessary for Northern Ontario. In addition, the Committee has considered the possible levels of responsibility required in a regionalized system, and the roles of these (the Province, the region, and the district) in the organizational structure.

SECTION II

Recommendations

PREVIOUS RECOMMENDATIONS

Previous reports of the Committee have included the following major recommendations, which have already been approved by Council:

a. That the organization and development of the several interrelated health services be carried out on the premise of providing the best possible total health services for the people of Ontario within a regional organization.

b. That such regional health organization should be based, in general and where specifically applicable, on university spheres of influence and interest and that every reasonable means be taken to assure that the health sciences centres of these universities are capable of assuming an active dual role in education and research, as is their prime function, as well as in continuing education, re-training and service consulting in both the professional and semi-professional aspects of the total health services with which they may be totally or in part responsible.

c. That the implementation of a regional plan for total health service be based on at least two levels of authority and responsibility, the region and districts within each region.

NEW RECOMMENDATIONS

Five additional recommendations of principle are now made by the

Committee:

a. That councils be established at the regional and district levels to exercise the authority and responsibility delegated by the Province.

b. That the Province have the role of providing policy guidance, of setting standards and of assessing the overall effectiveness of the system.

c. That the regional council have the role, based on provincial guidelines, of planning for the provision of health services within its region, to ensure that efficient, effective and economic use is made of available manpower, facilities and funds.

d. That the district council have the role, based on provincial guidelines and the regional planning programme, of organizing the provision of health care for the residents of the district, and of co-ordinating operational functions.

e. That a detailed study be made of methods of implementing a system of regional organization for Ontario.

Furthermore, the Committee recommends that the system of regional organization of health services include the following essential ingredients.

FUNCTIONS IN A REGIONALIZED SYSTEM

Province

The Province should have overall responsibility for health services* for the people of Ontario. The Ontario Council of Health would serve as the senior advisory body on these matters. In order to meet the responsibilities with respect to a regionalized system, the Province should have the following functions:

a. the delineation of health regions and districts. The decision on boundaries should not be immutable, and regional councils should have the opportunity to make recommendations to the

* The term "health services" includes preventive and curative services for physical, mental, and public health, but may exclude those environmental control programmes which require some different type of geographic organization.

Province about boundary adjustments;

b. the overall planning and guidance for the provision of health services, recognizing the particular needs of each region. This would include the setting of policies, standards, and guidelines which would form the framework within which each regional and district council would function;

c. the provision of consultative services which are not required on a continuing basis by regional and district councils;

d. the collection and analysis of data for use in evaluating the effectiveness of the health care delivery system;

e. the maintenance of financial control by using a system which will ensure that commensurate financial authority and responsibility are delegated to the appropriate level of organization—the region and the district. The regional and district councils will not be executive bodies.

Regions

Regions should be established by the Province. A region should consist of a number of districts, and should include a health sciences centre, recognizing that special arrangements might be necessary for Northern Ontario.

Regional councils should be established in accordance with the policies developed by the Province. Each regional council should consist of approximately 20 members, who should represent a balance of interest among the providers and consumers of health care, of each district council, of the health sciences centre, of local government, and of other related agencies and services.

The regional councils, based on provincial guidelines, should:

a. set goals recognizing the health needs and concerns of the citizens within the region;

b. develop plans for the provision of services, programmes and facilities to ensure that health care will be available and accessible to all residents of the region;

c. co-ordinate the health services programmes and the resources of

manpower, facilities, and finances for the region;

d. in collaboration with the Province, evaluate the effectiveness of regional programmes;

e. exercise financial authority commensurate with their assigned responsibilities.

Districts

A number of districts should be formed within each region, consideration being given to such factors as population density, population distribution, distance, and regional government boundaries.

District councils should be established in accordance with the policies developed by the Province. Each district council should consist of approximately 20 members, and should represent a balance of interest among the providers and consumers of health care, of local government, and of other related agencies and services.

Within the framework of provincial guidelines and standards, and the regional programme, each district council should have responsibility to:

a. participate with the regional council in the planning process;

b. maintain close relationships with the providers of health care;

c. co-ordinate the operations of the organizations providing health care to ensure a balanced, efficient, and economic service in the district;

d. exercise financial authority commensurate with its assigned responsibilities.

INITIAL ROLE OF THE PROVINCE

In order to achieve the goal of developing a regionalized system of health services, the Province should:

a. form regions and districts within the province;

b. establish a procedure for the formation of councils at each of

these levels;

c. be prepared to undertake such re-organization as may be necessary among the agencies for which the Minister of Health is responsible, in order to ensure effective operation of a regionalized system;

d. assess financial implications associated with a regionalized system.

FINANCING HEALTH SERVICES

The complicated nature of the present regulations, methods and procedures for financing facilities and programmes related to health care is illustrated in Appendix B.

To establish an effective financial system which would support a regionalized health care programme, the Province should:

a. develop policies for financing health care in a regionalized system;

b. adopt methods of financing control which will ensure that financial authority is appropriately delegated to regions and districts;

c. review and, where necessary, amend present acts, regulations and procedures to enable a more effective application of these financial policies.

Appendix A

BACKGROUND PAPER ON REGIONAL ORGANIZATION

CONTENTS

FIGURES

(All figures are assembled at the back of this Appendix)

SECTION I

Introduction

A. THE CONCEPT AND PURPOSES OF REGIONAL ORGANIZATION

The term region connotes different things to various people. The economist, the planner, the geographer and the political scientist each defines and draws a region in his own way. Nor is there widespread agreement within any of these groups as to the characteristics of a region. To a political scientist, for example, the term may suggest various concepts—an area for the administration of a service provided by a senior level of government or a new tier of multipurpose government established between the provincial level and the local municipalities.[1]

In its simplest terms, applied to the health field, regional organization refers to the establishment of working relations among various health facilities and programmes within a defined geographical area. Too often, regionalization is wrongly conceived of in broad geographical terms only. Properly viewed, it includes the working out of relations among facilities in a given town or county as well as many towns or counties, perhaps to the extent of combining the elements in one large institution. The general purpose of regional organization for health is to equilibrate the quality and quantity of care available to the general population by the conscious process of sharing limited skills and facilities.

Scarcity, specialization, and the pressure of rising costs, are among contributing factors to the need for regional organization.

Scarcity is a relative term which applies to either manpower or facilities in the health field. Notions of scarcity change as the whole level of medical services inches upward. Since it is not possible to define the "need" for medical services readily, the notion of scarcity implies some general concensus as to what might reasonably be provided at specific points in time in specific places.

Specialization has undoubtedly contributed to the interest in regional organization. As medical science has expanded, it has made possible more services than one man could perform well, or even understand. The result is specialization. The emergence of specialists necessitates some kind of arrangement to co-ordinate their individual contributions to health care. Regional planning is one answer to the problems posed by extensive specialization among those providing medical services.

Because of the ever rising costs of health care, there is broad agreement that every step consistent with high quality of care should be taken to control costs. Concern about costs varies widely, depending upon the amounts of money available and the need, but in general any scheme which holds promise of controlling costs is likely to be widely supported. Regionalization holds such promise.

B. THE COMMITTEE ON REGIONAL ORGANIZATION OF HEALTH SERVICES OF THE ONTARIO COUNCIL OF HEALTH

Considerable impetus toward regional organization for health care was given by the reports of the Royal Commission on Health Services (Hall Commission)[2]. After examining in depth the organization of health services across Canada, the Commission came to the conclusion that "an essential element in the provision of the best possible health care for Canadians was the improved organization of health services." Among the details of recommended organizational re-structuring were the following:

(a) **Provincial Health Planning Councils.**

"To ensure democratic participation in the setting of goals and objectives of the health services programmes, a provincial Health Planning Council should be appointed by the provincial government from panels nominated by professional bodies, voluntary

organizations, university, municipal, farm, business, labour and other representative associations."

The principal responsibilities of the Council would be to make recommendations relating to (1) programme development and the improvement of health services within the province; (2) the medium and long-term needs of the province for personnel and facilities; (3) proposals for new government and voluntary activities in the field of health services; (4) the recruitment of health personnel; (5) *the co-ordination of the activities of professional personnel, voluntary organizations, and governments in the area of health service.*

(b) **Regional and local Health Planning Councils.**

"Where the size or diversity of a province warrants it, regional and local or municipal health planning councils should be established in the same manner as the provincial Health Planning Council."

In Ontario, the first of the above recommendations was, of course, accepted and implemented with the formation of the Ontario Council of Health. The Council, through its various committees, is now discharging its responsibilities, including the investigation of means by which the second of the above major recommendations, the formation of regional and local Health Planning Councils, may be implemented.

SECTION II

The Role of the Ontario Government in Regional Organization

A. PROVINCIAL GOVERNMENT DEPARTMENTS

There are 19 government departments and all but one or two operate one or more sets of field offices with consequent sets of regions or districts. It is an individualistic and, at first glance, a chaotic picture, with 60-70 operations administering areas of different purpose, size, and shape, and differing widely in the scope and importance of their functions and responsibilities. To these departmental districts, of course, must be added those of a number of non-departmental Boards and Commissions, some of which are of considerable importance to both regional planning and departmental operations, e.g. the Ontario Water Resources Commission and Ontario Hydro.

The majority of field operations are functionally administered by programme branches at head office. The number, size, and shape of the administrative districts adopted by this multitude of programme branches have been shaped by numerous factors—transportation routes and methods, means of communication, the need to be close to the persons dealt with or the objects administered. Though the districts and boundaries may not be the result of precise planning, they do represent, in the considered opinions of the various departments, the most effective area arrangements for administration and budgeting.

Significant changes to existing patterns of the departmentalized, functional pattern of regionalism seem certain to take place in the long run, however. The two main forces for change are the emphasis

currently placed upon economic planning and the restructuring of local governments to equalize standards of services among them.

In a study of regional organization for health care, two departments of the provincial government, apart from the Department of Health, are of particular interest because both provide personal services and the interests of both overlap to a significant extent with the health field. They are the Department of Education, which has recently completed a drastic reform in organization, and the Department of Social and Family Services, which has extensive field operations administered through regional offices.

1. Department of Education

Over the past two decades, there has been a steady trend toward the consolidation of small school divisions. In 1945, there was a total of 5,649 elementary and secondary school boards. By 1963, this staggering number had been reduced to 3,216 primarily through consolidations of public school sections. In 1964, legislation which established the organized townships as the basic unit of administration for public school purposes cut the total to 1,673. Another much more abrupt round of reform was announced in January 1968 to take effect in January 1969[3]. This innovation will drastically reduce the number of school authorities: this time, from the 1964 figure of 1,673 to 78. Existing authorities have been replaced by single school divisions responsible for both public and secondary education in each of the 38 counties of Southern Ontario; existing boards of education in the five largest cities of the province will be retained, and 30 new school divisions will be established in Northern Ontario: a total of 78.

The most recent re-organization is intended to achieve three major objectives. The first of these is to equalize educational opportunity throughout the province while the second is to provide for a more equitable distribution of education costs. Both of these goals can only be achieved by the formation of larger territorial units which offer a larger student clientele, a wider and larger tax base, and which allow more specialized and diverse teaching resources to be deployed. The third objective is to decentralize educational decision-making by creating units capable of assuming the degree of autonomy which is required if education is to adapt to and reflect the varied needs and priorities of different parts of the province. The flexibility of

the educational programme and its sensitivity to community and pupil need formed a central theme in a recent important report, the Hall-Dennis Report on education in Ontario[4]. In this important respect, the legislation creating the regional education authorities can be said to be in accord with a strong current of thought about education in the province.

2. **Department of Social and Family Services**

The work of the Department has the following main aspects:

(a) Allowances to individuals and families.

(b) Subsidies and supervision of municipal social services and children's aid societies.

(c) Subsidies and supervision for institutions for the aged, for the handicapped, and for children.

(d) The operation or support of rehabilitative and auxiliary programmes.

The Department is organized into a head office and two divisions: the Programmes Division and the Finance and Administration Division, both of which have constituent branches. The Department is involved in both direct service programmes, which are administered through a field staff of approximately 500 working from regional offices, and in the supervision and subsidy of programmes for which municipalities have responsibilities.

The field staff operates from offices located in 19 regions covering the entire province (see Figure 1). The regions comprise aggregations of counties (averaging about three counties per region) or, in the case of northern Ontario, districts. The regional office is usually located in the dominant urban centre of the region. The field workers gather applications and reports and forward them through the regional office to the head office branch concerned. For most purposes, the regional office represents the Department in the area it serves.

The consolidation of municipal welfare services on a county-wide basis has been encouraged by the Department and in the last five years the municipalities of ten counties and six districts have

unified to form County or District Welfare Units. Because of the need for the Department to supervise and subsidize municipal welfare programmes, it is anticipated that any future changes in the regional boundaries will continue to conform to appropriate municipal boundaries. In other words, if regional local government were instituted, the Department's regions would comprise one or more entire regional local government units just as they now include several counties. Most of the regional offices would remain as at present though the boundaries of the region they serve might well change.

B. REGIONAL ECONOMIC PLANNING

The Economic Regions of Ontario

In the early 1950's, the federal Department of Defence Production, with provincial assistance, divided the whole of Canada into regions, based on groupings of areas which form structurally and functionally related units, and which were considered the largest areas for which useful generalizations could be made. The System evolved was known as the "D.D.P. Geographic Code[5]." Combinations of counties were used because of the need to frame regions for which it would be possible to obtain significant statistics.

By 1954, the original plan had been modified somewhat and this modified version, comprising ten regions for Ontario, was adopted by the Ontario Government (see Figure 2). Within each region, the Government established a Regional Development Association—now called a Regional Development Council. The primary objective of the Councils, which have representation from local government and associations within the region, is to advise the Province on matters affecting the overall economic development of the region. The ten economic regions have been the object of intensive study by the Regional Development Branch (originally with the Department of Economics and Development and now with the Treasury).

In 1966, the Prime Minister of Ontario made a policy statement on regional development entitled *Design for Development*[6] in which he outlined the government's programme for "guiding, encouraging and assisting the orderly and rational development of the Province." Because of government's commitment to regional planning and development, the eventual adoption by the various departments of

common administrative districts was noted as a policy objective. It was proposed that interdepartmental co-ordination and planning be achieved at headquarters through a Cabinet Committee and a top-level interdepartmental committee, and at the regional level by regional advisory boards comprised of regional administrators of selected government departments. Regional Development Councils, representative of local government and associations, are intended to be active partners in the development of regional studies and plans.

C. REGIONAL LOCAL GOVERNMENT

The provision of local services in Ontario presents a very complex picture. Not only are there more than 900 multipurpose municipalities but also in excess of 2,000 ad hoc authorities and/or special districts[7]. In addition to these units, there are the provincial departments and agencies described in Section II A and B above.

For local government administrative purpose, Ontario is divided into northern and southern sections. In the southern section, municipal organization is complete with 38 counties comprised of separately incorporated municipalities. Except for the cities and separated towns, these local municipalities send representatives to the county council. Although they do not participate in county government, cities and separated towns are required to contribute to the costs of certain services which the county provides for its entire geographical area. In northern Ontario there are seventeen districts which provide local government services with the help of several provincial departments. Where there are incorporated municipalities within these districts, the latter provide the municipal services.

At present, 90 per cent of Ontario's municipalities have a population of below 10,000 and the median population figure is only 1,775. The obvious inefficiencies of such a number of small units, and the inequalities in the standards of service provided by them, are currently the cause of great interest and concern both at the local and provincial government level. The two most significant efforts to suggest a rational system of viable local government have been a series of local government *reviews* and the Ontario Committee on Taxation (Smith) Report[8].

1. Local Government Reviews

In 1966 and 1967, eight local government studies were commissioned by the Minister of Municipal Affairs with the consent of the Cabinet. Each of the studies was carried out by an independent Commissioner supported by a small research staff. The studies in Ottawa-Carleton[9], the Niagara peninsula[10], Peel and Halton Counties[11], and the Lakehead region[12], have been completed and the final reports of the other four, Muskoka, Hamilton-Wentworth, Waterloo County and Brant County, are expected within a few months. The major recommendations of the Ottawa study have been accepted by the government and implemented in the form of legislation creating, on January 1, 1969, a regional municipality composed of Carleton County, the cities of Ottawa and Eastview, and Cumberland Township[13].

All of the local government reviews have recommended a two-tier system of some kind; as an indication of what might be expected in terms of consolidation, the Peel-Halton study recommended a reduction in the number of municipal units from 20 to 6 and the Niagara study from 28 to 13.

2. The Ontario Committee on Taxation

As its name suggests, the committee was not actually charged with responsibility for devising a system of regional government. However, it decided to do so on the grounds that such a system would facilitate creation of a "tax and revenue system that is as simple, clear, equitable, efficient, adequate and as conducive to the sound growth of the Province as can be devised."

The Committee reviewed in detail the development since the war of the consolidation of municipal units and the spate of legislation, provincial and municipal reports, and reports from private and professional groups on the subject. One such example, the Select Committee on the Municipal Act and Related Acts (The Beckett Committee), recommended in its final report in 1965 that the entire province be divided into larger units of local government designated as "regional . . . with suitable boundaries having consideration to population, assessment, logical planning areas and economic and social conditions."

Reaching similar conclusions, the Ontario Committee on

Taxation described in specific detail a two-tier regional system for southern Ontario comprised of three distinct classes of region: seven "Metropolitan Regions" surrounding the seven largest urban concentrations, three "Urbanizing Regions," and 12 "County Regions." Northern Ontario too had three classes or regions: two "Metro Regions," five "Northern District Regions," and large expanses of territory obtaining their regional services through contractual arrangements. Among 19 functions considered to be appropriate for the regional government were public health, hospital facilities planning, and public welfare. It was a major recommendation of the committee that the provincial government plan the detailed studies necessary for the implementation of the regional system within five years of the publication of the report. Explaining that the proposed regions were tentative, the Committee expressed the hope that the recommendations would provide a starting point for further and more detailed analysis. The further analysis was in fact not long in coming, being provided by the Select Committee of the Legislature on the Ontario Committee on Taxation[14].

THE SELECT COMMITTEE OF THE LEGISLATURE ON THE ONTARIO COMMITTEE ON TAXATION

The Select Committee was formed to review the work of the Ontario Committee on Taxation by September 1968, and recommend to the government as to its acceptance and implementation. The Select Committee accepted completely the concept of, and the urgent need for, regional government. In fact it was suggested that further studies as proposed by Smith were largely unnecessary and that implementation should proceed immediately in some areas and across the whole province by the end of 1971.

The committee also expressed general agreement with the list of 19 functions to be performed by the regional level of government, including those of public health, hospital facilities planning, and public welfare. The Select Committee did not agree with the recommendation that a two-tier scheme of regional government is necessarily desirable in every instance. The most serious criticism of the Smith Committee proposals, however, concerned the division of regions into "Metropolitan," "Urbanizing" and "County" classes. The Select Committee reported: "We are not convinced that adequate recognition has been given to the interrelationship between the cities and the rural areas surrounding them. We think that the Smith Committee's emphasis on the separation of the urban and rural areas

is wrong in principle. The best boundaries for regional government are those which correlate the urban, surburban and rural functions of an area to the greatest degree possible." The Select Committee did not suggest specific boundaries for the regional system they proposed but detailed a programme for the initiation, supervision, and co-ordination necessary for implementation.

THE CURRENT SITUATION

Action on the recommendations of the local government reviews, the Ontario Committee on Taxation Report, and the Select Committee report, has been prompt and positive. During the debate on the Throne Speech on December 2, 1968, Mr. McKeough, the Minister of Municipal Affairs, revealed details of the government's regional government programme. Implementation of regional government units will be a four-stage process in each area, giving full opportunity for discussions between municipalities and the Province. The government will proceed on a priority basis, giving its first attention to areas where the need is greatest. No target date has been fixed for completion.

Mr. McKeough said the government has decided to create regional government units with a basic population of between 150,000 to 200,000. Whether there will be smaller municipal governments within the regions will be decided separately for each region and will depend on distribution of population and geographical size. In previous speeches, both Mr. McKeough and the Prime Minister have said that the regional government organizations would follow the urban node system, with a central city at the heart and as much suburban and rural area surrounding it as could be economically supported. This will allow the regional government system to coincide with the regional development plan that the government expects to begin implementing in 1970. Mr. McKeough said that boundaries are not fixed at this time. In some instances the existing county boundaries may represent a logical regional unit but this may prove to be the exception rather than the rule.

Legislation will be proposed during this session to institute regional governments in the Muskoka, Niagara, and Lakehead areas. Moreover, a detailed study of regional government for the Sudbury area will be made within six to nine months. In addition to the above four regions, eight others would receive high priority attention:

Ottawa-Carleton: Legislation comes into effect January 1, 1969,

creating a regional municipality composed of Carleton County, Ottawa, Eastview, and Cumberland Township.

East Metro: A meeting with representatives of Ontario County and the extreme western section of Durham County will lead to specific proposals within 12 months.

West Metro: A 1966 study embodying urban and rural separation (The Plunkett Report) was rejected both by the Ontario government and local opinion. Preliminary discussions are under way with officials of both Peel and Halton Counties.

Hamilton Wentworth: A study by a local government review commission will report to the Minister within six to eight months and the report will be followed by a specific proposal from the Minister.

Waterloo Area: A detailed study is almost finished. A specific proposal for regional government is expected from Mr. McKeough within 12 to 14 months.

Brant: Local and provincial-local discussions are under way with the possibility of a regional unit larger than Brant County under consideration.

Haldimand-Norfolk: New industrial development has prompted a detailed planning study with the result expected to indicate the need for regional government.

Northern Ontario: A study to determine structural form, the extent of regional government power, provision of services in unorganized areas, and other factors, should be completed by July 1, 1969.

SECTION III

Existing Regional Patterns of Health Care in Ontario

A. DEPARTMENT OF HEALTH

The Department of Health is organized on a functional programme basis into four divisions. These divisions are Mental Health, Public Health, Medical Services Insurance, and Financial and Administrative Services Division. In addition, the Department has supporting branches—Legal, Personnel, Information, and Research and Planning Branch. Two of the four divisions, Mental Health and Public Health, have a form of regional organization.

1. Mental Health Division

This Division is responsible for the planning, development, and administration of a programme of mental health services to meet the changing needs of the province. It is divided into four branches: Psychiatric Services, Mental Retardation Services, Professional Services and Hospital Management Services. Psychiatric Services operates the mental hospital system of 16 hospitals, with about 14,000 beds; the branch for the Mentally Retarded is responsible for nine facilities for the retarded, with about 7,500 beds; the Hospital Management Services Branch provides consultants in all aspects of hospital management and is a back-up service for both of the operating branches; Professional Services are consultant and advisory, not only to the provincial institutions, but also for outside agencies.

Children's Services Branch – A Children's Services Branch is being established to implement arrangements for children as described in the White Paper, *Services for Children with Mental and Emotional Disorders*[15]. There will be eight regional centres–at Ottawa, Kingston, Toronto, Hamilton, London, Windsor, Sudbury, and Port Arthur–and this Branch will co-ordinate arrangements in all provincial institutions for children.

2. Public Health Division

The aim of this Division is to consolidate existing public health activities into a single programme, with the Division serving as the focal point between the Department and official health agencies at the local level. Four branches in the Division represent the major activities: they are Local Health Services, Environmental Health Services, Special Health Services, and Laboratory Services.

Local Health Services Branch – The Branch has six units–an executive office in Toronto and five regional offices located as follows: Southwestern in London; Midwestern in Hamilton; Central in Toronto; Eastern in Kingston; Northern in Toronto. The primary purpose of the Branch is to stimulate, guide and assist the progressive development of public health services across the province. The regional organization works closely with local health units. Local health units are being consolidated into district health units, with 29 districts being identified for the province (see Figure 3). The provincial contribution to operating costs of districts is 75 per cent. This increase in provincial contribution is being made with the firm understanding that the acceptable programmes will have to be developed in all aspects of public health. Twenty-two of the 29 districts have already been formed.

The Environmental Health Services Branch stresses environmental management and deals with matters such as public health engineering, waste management, air pollution control services, occupational health, and civil service health. Air pollution control is a major operating service and was accepted as a provincial responsibility in 1967. A five-year programme was outlined in the House for the development of a comprehensive air management system.

The Special Health Services Branch includes drug testing and a biologics programme, epidemiology, medical rehabilitation and chronic care, maternal and child health, nutrition, and tuberculosis prevention. All of these services provide consultant and advisory arrangements in their special fields. Since late 1967, nutrition consultants have begun to provide their services at the local level from the offices of the Regional Medical Officers of Health rather than from their Toronto headquarters. It may be that other Branch services could be similarly decentralized, while continuing to operate under central office direction.

The Laboratory Services Branch operates a system of public health laboratories, with the central laboratory being located in suburban Toronto. "Regional" laboratories are situated at 13 locations as follows: Fort William, Kenora, Timmins, Sault Ste. Marie, North Bay, Palmerston, Windsor, London, Woodstock, Orillia, Peterborough, Kingston and Ottawa. Five hospitals, at Sarnia, Kitchener, Stratford, St. Catharines, and Cornwall, provide an associated laboratory service. While the primary function of this laboratory system was medical microbiology, sanitary bacteriology, and serodiagnosis, there has been an increasing emphasis on clinical laboratory work. This was necessary because hospital laboratories tended to confine their activity to hospital patients and did not provide for patients requiring laboratory tests in the community. The Province recently introduced a billing procedure for clinical tests.

B. THE ONTARIO HOSPITAL SERVICES COMMISSION

The O.H.S.C. operates the Ontario Hospital Services Plan which has been in operation since 1959. The Commission is basically divided into two distinct areas–Hospital Services and Finance. Hospital Services is responsible for the development of a balanced and integrated hospital system and for providing advice on the standards of hospital care. The internal hospital financial operations are under the control of the Commissioner of Finance.

O.H.S.C. Regions–Figure 4 indicates the regions into which the province is divided by the Commission in its programme of *planning* to meet needs for hospital beds and services. These regions are *not*

used for administrative purposes. The map indicates, in a generalized fashion, the areas from which patients are referred to regional centres. These are usually university centres, which provide the specialized types of care that cannot be made available by local hospitals.

Figure 5 shows the division which is under consideration for regional planning purposes. The main objectives of the Commission's regional planning programme are:

(a) to meet the hospital needs of the community as a whole by making necessary beds and services available to provide high quality care;

(b) to eliminate unnecessary duplication of beds and services;

(c) to permit maximum utilization of professional and technical personnel; and

(d) to achieve these with the greatest economy of financial resources.

Hospital Planning Councils—The Commission has for some years been considering means of achieving co-ordination among groups of hospitals to assist in the overall development of the Province's hospital system. For this purpose, the Commission over the past two years has been promoting and assisting in the development of hospital planning councils.

A planning council may be formed at community, district or regional level to correlate hospital functions and services within a geographic area. Several types of planning council have evolved. Some have representatives appointed by local municipal councils together with community, hospital and medical society representatives. Others have representation from hospital boards, medical staff and hospital administration.

Hospital planning councils are strictly advisory in function. They are designed to give advice to hospitals, local governments or groups interested in hospitals within communities, districts or regions, in matters of hospital planning, development, co-ordination and capital financing. They are also designed to make recommendations to the Commission on the planned development of hospitals and hospital services in their area and to promote liaison between communities, districts, regions, and the Commission.

The functions of planning councils can in no way supersede the functions of the Commission and all plans and programmes developed by a planning council must be submitted to the Commission for approval. The consultative and research services of the Commission are available to planning councils, although in certain instances a planning council may be authorized to undertake investigations.

Finally, it is foreseen by the Commission that hospital planning councils may develop into *health* planning councils concerned with all health services in their areas.

C. HEALTH SCIENCES CENTRES

The emergence of Health Sciences Centres has provided a key element for a system of regionalized health services. Health Sciences Centres are university-based complexes which are intended to combine teaching, research, and service, in the ways which make the most rational use of financial resources, teaching personnel, and physical facilities, and which also attempt to teach and train the members of various health professions in an integrated manner.

The Health Sciences Centre differs from the traditional medical school in several notable aspects. It usually incorporates a "University" hospital as an essential component. It provides a more prominent role for the basic sciences, both the life sciences and the behavioural sciences. It affords the facilities for research for the various segments of the health professions. Its importance is reflected in the fact that it usually warrants its own vice-president in the university to direct its manifold activities. Health Sciences Centres seem destined to dominate the health sciences much as did major medical schools and medical clinics in previous decades. They will be the centres for research, for teaching and for service.

As noted earlier, teaching in the health field has become progressively more complex. Many more specialized occupations have emerged to make use of a somewhat similar subject matter. The problems of teaching, in an integrated fashion, the practitioners who will be teamed in diverse ways when they enter practice is a difficult one. So is the problem of continuing education, a matter which becomes increasingly acute with the rapid pace of change in medicine.

The Health Sciences Centre currently offers the best hope that such teaching can be successful. It also offers promise that the evolving demands for service can be met. These demands have expanded along new fronts. Particularly important are the services which need to be continued as "Community" services rather than traditional personal services. Of like importance are the services that go beyond the community, such as those involved in dealing with environmental hazards, of which pollution is an obvious example. It seems fair to assume that only the Health Sciences Centres will be in a position to mobilize the resources (teaching, research and service) and the sophisticated expertise required to handle these new demands of medical care.

Health Sciences Centres have emerged across the whole of this continent during the last decade. In Ontario there are five such complexes, in which the chief buildings will be operational by 1975 (see Figure 6). The Health Resources Fund, established in 1966, gave a substantial impetus to their development in this province. It is to be expected that they will progressively attract to themselves the most illustrious teachers, research personnel, and practitioners, who will be in a position to play an important role in shaping the organization of the health education, research and services in the regions in which they are centred.

SECTION IV

Regional Health Planning in Other Countries

The administrative plans for health, social security and welfare in operation in any country are the results of gradual development superimposed on national and local government systems and the social structure and culture of that particular country. It has been suggested by some experts in the field of international health and social services that, with some considerable simplification, the health services of the world can be classified into four main types of system[16, 17].

1. **The Western European** type developed in its most characteristic form in central continental Europe but with a number of features common to the whole family of Western European countries. This type includes the United Kingdom which, however, differs from most other countries in some respects, notably in the nationalization of the hospital system.

2. **The American** type to be found in the United States of America, partly in Canada and other countries ideologically and geographically close to the United States of America.

3. **The Soviet Russian** type which was introduced through the Russian revolution in 1917 and spread from the Soviet Union to neighbouring Communist countries and later also to China and certain other countries in Asia.

4. The ad hoc type gradually taking form in the so-called developing nations of the world.

Though pioneering efforts in health planning were made as early as the 1920's, it was not until after World War II that the planning of health services became a prominent national issue—mainly in the under-developed countries. "The post-war period of reconstruction gave a fresh opportunity to new governments, like that of India, to build their health systems according to some sort of ideal model in a step by step process."[18] There were similar bold approaches in Israel, South Africa, Indonesia, and elsewhere.

In many countries such systems seem to work well; they may appear as an enticing solution for Canada's health services. There are, no doubt, lessons to be learned from the Soviet system and others but, if we are to learn from the experience of others, as we should do, it should be not a matter of copying but of selectively adapting, and still preserving what is good about the existing situation.

"In the more affluent countries, not so devastated by the War or political upheaval, like Canada and the United States, progress in organization of health services has been substantial but on a more piecemeal basis. In both countries, the chief movement has been in the sphere of improved and collectivized methods of financing, mainly through the insurance device. Voluntary insurance for hospitalization expanded rapidly. In Canada its success, along with the even greater impact of the social insurance model in Saskatchewan after 1947, led to the nation-wide federal-provincial hospital insurance programme in 1957."[19] The Royal Commission on Health Services was appointed in 1961 and its report was issued in 1964. Many bold measures were called for, but the most important was doubtless the proposal for nation-wide insurance for physicians' services. After the usual debates, legislation to carry this out was passed in 1967 and, although there are some unsettled problems in provincial-federal relations, the programme will be implemented. With organized financial support for the bulk of hospital and physician services—constituting about two-thirds of all national health expenditures—Canada will soon be in a position to move ahead even more rapidly in systematic planning of its total health services.[20]

The two countries, whose health planning systems seem likely to provide the most valuable experience, are the United Kingdom and the United States. The health service of the United Kingdom is sophisticated and long-established but still evolving; though it has a strong element of national central control, there is a good deal of autonomy at the regional level, including the extremely

important element of financial control.

The United States health system shares with the Canadian a fragmented character with a complex set of relationships between public and private sectors. As in Canada, some advances are being made toward improved and centralized methods of financing (Medicare), though progress has been slower in the United States. The federal system of government, which involves the individual states directly in responsibility for health care, is another important area of similarity with Canada, as are many other facets of the political and social systems. Though progress may have been slow in some areas, a strong point in favour of the United States approach is that there has been no rigid adherence to a single-minded monolithic system. Instead, a multiplicity of different approaches is being taken, which should offer a great variety of experience to suit an equally wide range of regional and cultural differences.

The following is an extremely brief description of the current situation in the health planning field in the United Kingdom and in the United States:

United Kingdom – In the National Health Service of the United Kingdom, health care and treatment of all kinds of illness are accepted as a state liability. Almost all hospital accommodation, including university hospitals, has been nationalized and is vested in the central government (Minister of Health in England and Wales, the Secretary of State in Scotland, and the Minister of Health in Northern Ireland). The country is divided into hospital regions which do not coincide with any form of local government.

General practitioner care is available to all without charge. General practitioners are not state employed but are individually in contract with the health service. There is no formal or financial barrier to co-operation between staff of the three main branches of the health service–hospital, general practice, and Local Authority Services (Public Health)–but this tripartite arrangement has been much criticized as one of the most serious shortcomings of the Service.

Two extremely significant studies proposing sweeping reforms in the National Health Service were published in August 1968. One study, *The Administrative Structure of the Medical and Related Services in England and Wales*[21], the so-called "Green Paper," proposes among other reforms a sweeping away of the above

mentioned tripartite system and a thorough unification of all arms of the Service. Furthermore, it is proposed to replace the existing 700 health authorities, comprised of hospital management committees, regional hospital boards, and local (public) health authorities, with 40-50 area boards. The second important study is the *Report of the Committee on Local Authority and Allied Personal Social Services*[22], the "Seebohm Report."

The main recommendations of the report were organizational—to set up a social service department under a social service committee, which would unify a number of local authority departments (welfare, housing, services for children, for the elderly and physically or mentally handicapped, etc.) to provide a family service. The new department should work at field level with teams of 10 to 12 social workers serving population areas of between 50,000 and 100,000.

The experience of 20 years with the existing health service, and the dialogue surrounding the Green Paper and Seebohm Report and the possible implementation of their recommendations, are bound to provide any jurisdiction involved in the regionalization of health services with a great deal of valuable intelligence.

U.S.A. – Regional organization for health care in the U.S. had tentative beginnings in the 30's and 40's, principally with respect to hospitals and postgraduate education. The first widespread advances began in the early 1960's, when the federal Public Health Service gave grants-in-aid to the locally organized, regional voluntary health facilities planning bodies. These have grown in number from one in 1945 to a handful in 1960 to about 80 at the present time.

Of far greater significance, however, are two major programmes recently established by the Congress, both of which involve the regionalization of health services. They are: the Regional Medical Programme for Heart Disease, Cancer and Stroke (Public Law 89-239) and the Comprehensive Health Planning and Public Health Services Amendments of 1960 (Public Law 89-749).

(a) **Regional Medical Programme**: The purpose of the Regional Medical Programme is, in the words of the Congress: "Through grants, to encourage and assist in the establishment of regional co-operative arrangements among medical schools, research institutions and hospitals for research and training (including continuing education) and for related demonstrations of patient care in the fields of heart disease, cancer, stroke

and related diseases."

The approach to implementing this programme is visualized first as a regional planning process followed by operational grants for specific projects, the need for which is defined in the planning process[23]. The planning must be done by a non-profit agency and, since a major thrust of the act is directed towards involving the personnel, skills, and knowledge, of medical school centres in the health service programmes of the region, most planning agencies have been formed as a result of primary initiative from the medical school centres.

A requirement of the planning organization is a regional advisory group broadly representative of medical institutions, agencies, professional groups and the public. By July 1968, 54 planning grants had been awarded and it was estimated that 98 per cent of the population of the U.S. was living in regions covered by planning grants. In the year ending June 30, 1968, 23 Regional Medical Programmes had received operational grants.

(b) **Comprehensive Health Planning**: Under this act, the federal government authorizes the states to establish or designate a single agency for comprehensive health planning, to appoint an advisory council, and to complete a state plan that will form the basis for federal support to state and local health activities[24].

Beyond certain minimal requirements of organization and submission of plans, the act displays few sharp teeth. On the other hand, in its strong invitation to the varied elements of the health "industry" to find ways and means to seek out mutual advantages, while serving the common good, the law distinctly keeps within the realities of the American political and social system.

In summary, the act highlights the problem of fragmentation in the health field, implies a co-ordinative role for state governments, and backs up a prejudice for comprehensiveness by attaching federal supports to "comprehensive state plans" without their precise definition.

It seems clear that the Congress intends comprehensive health planning to be a "global" effort, bringing together what is done in the environmental health field, in the Regional Medical Programme, and in the health facility and manpower

planning—with an emphasis throughout on regional considerations. Probably this new emphasis on regionalization is derived principally from the changed nature of life in the U.S., especially the trend toward "metropolitanization." This new set of living conditions is inducing many changes, particularly in the "service" fields such as transportation, education—and now health.

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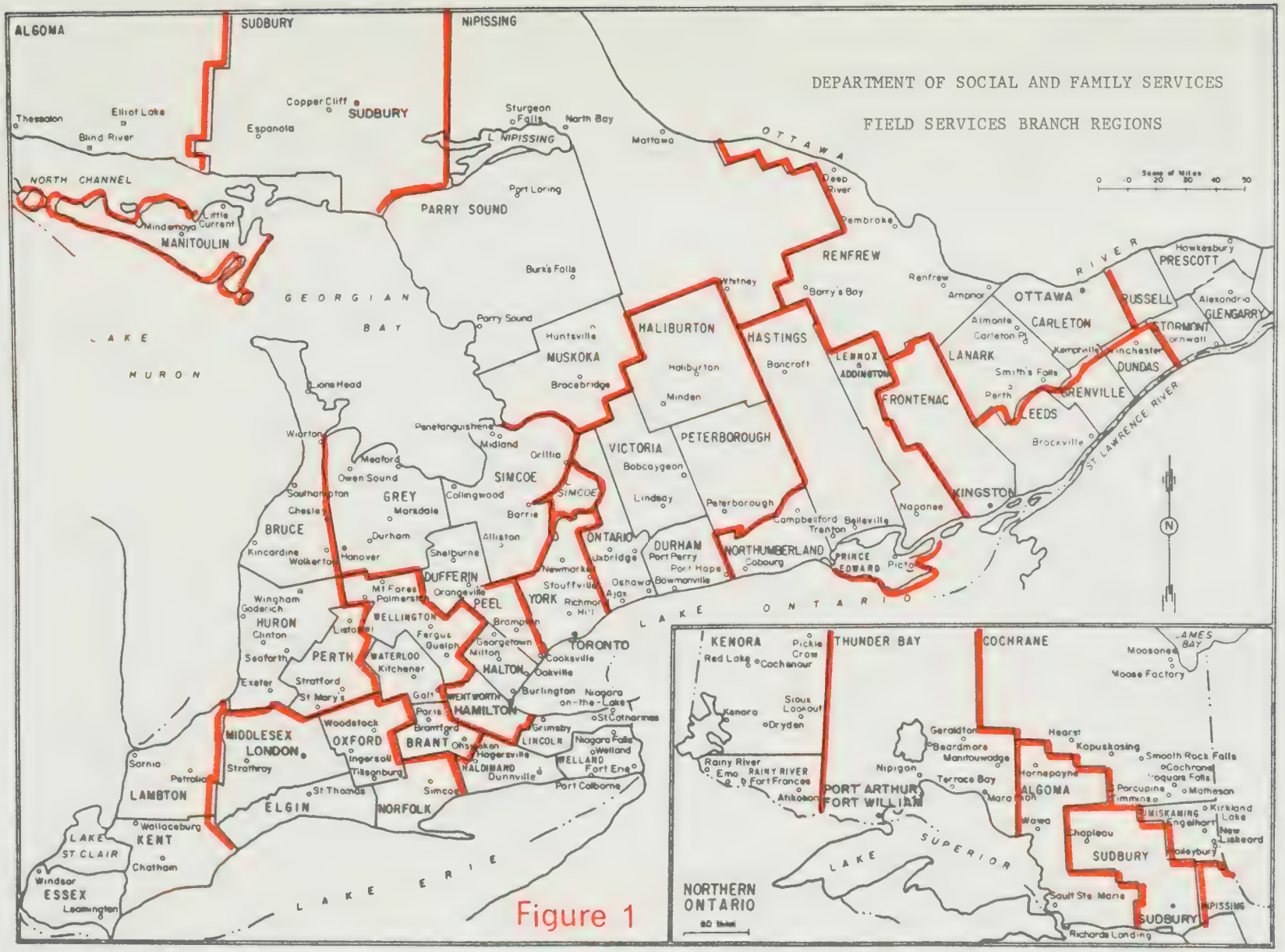
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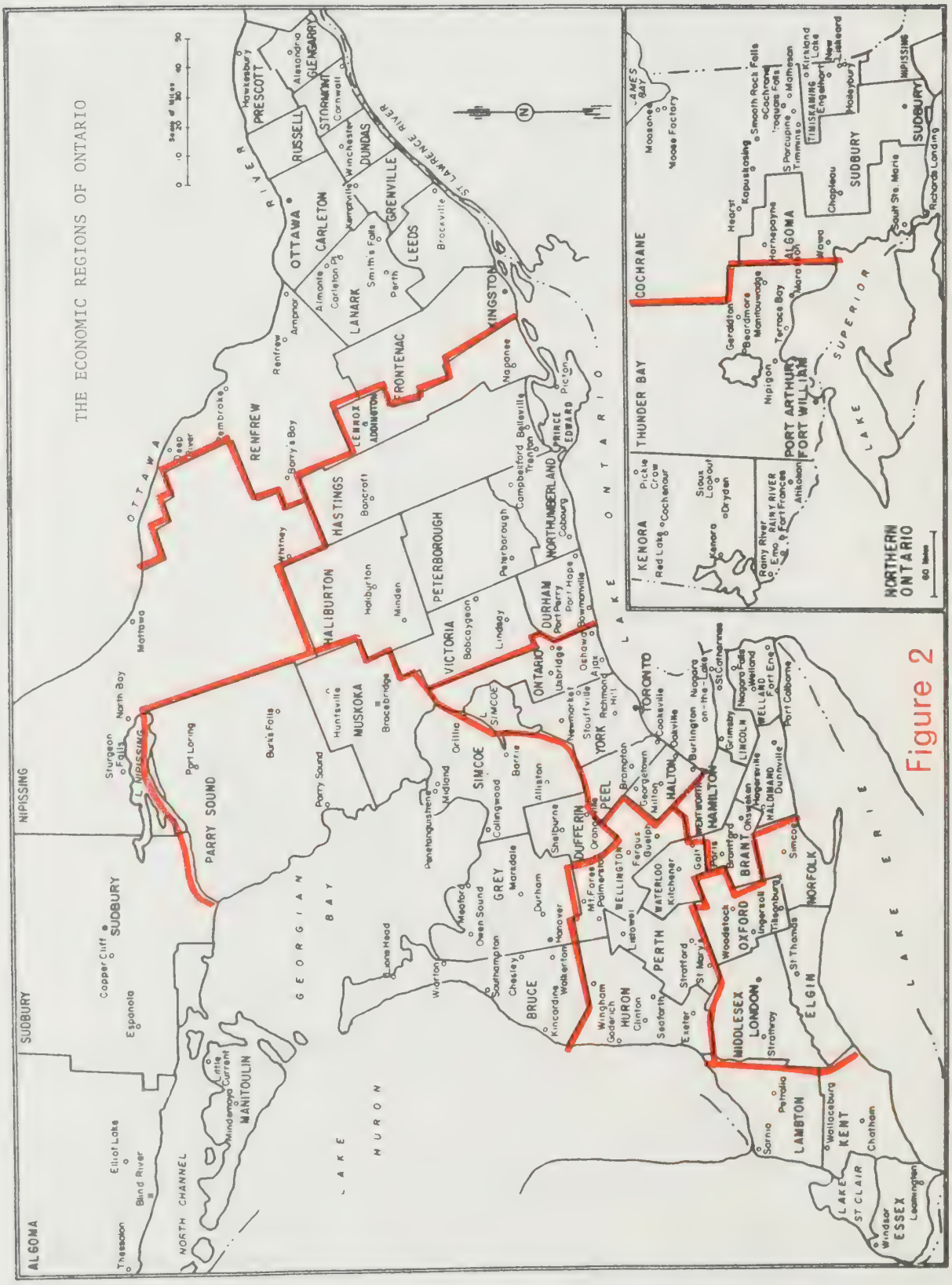
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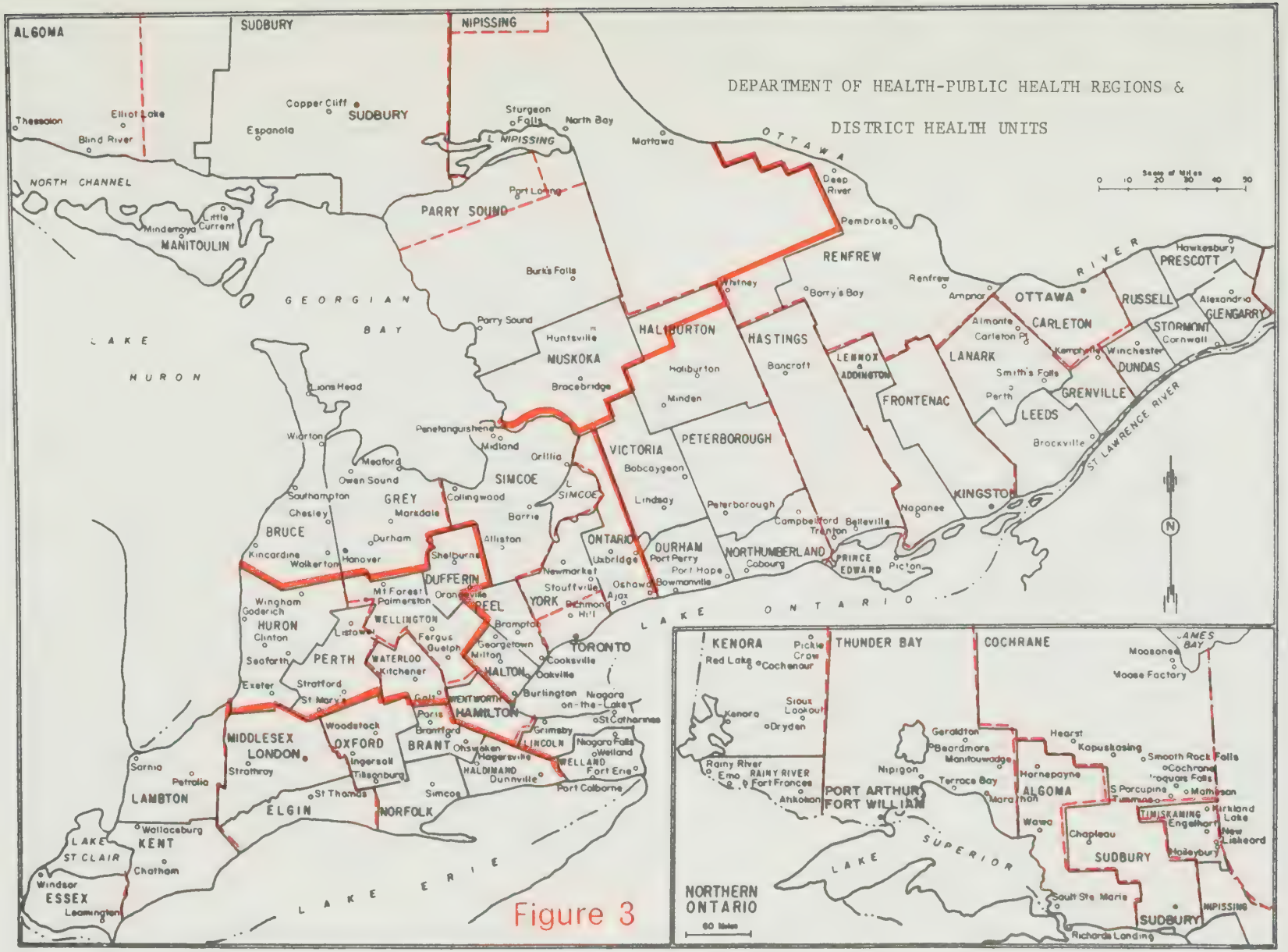
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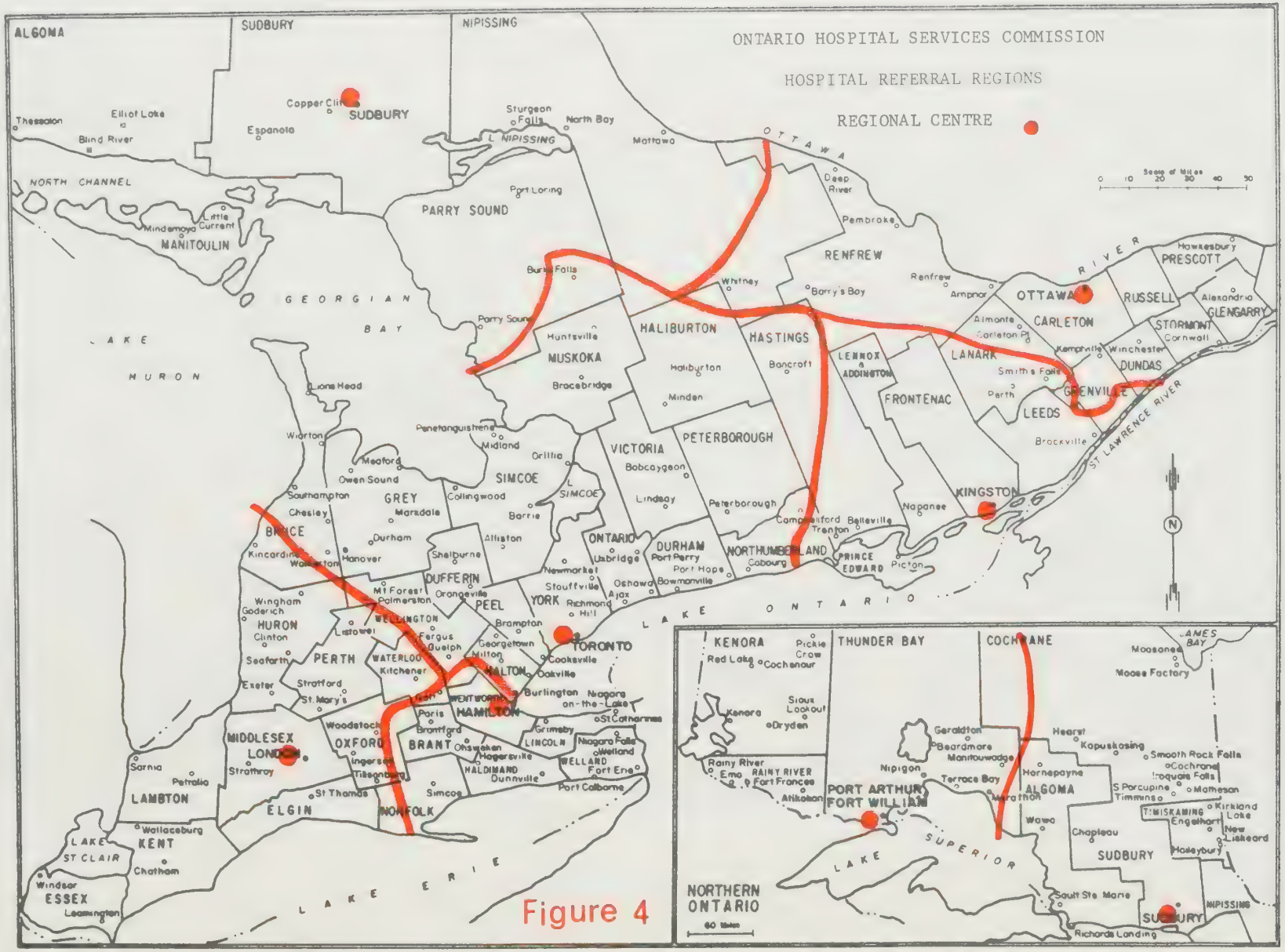
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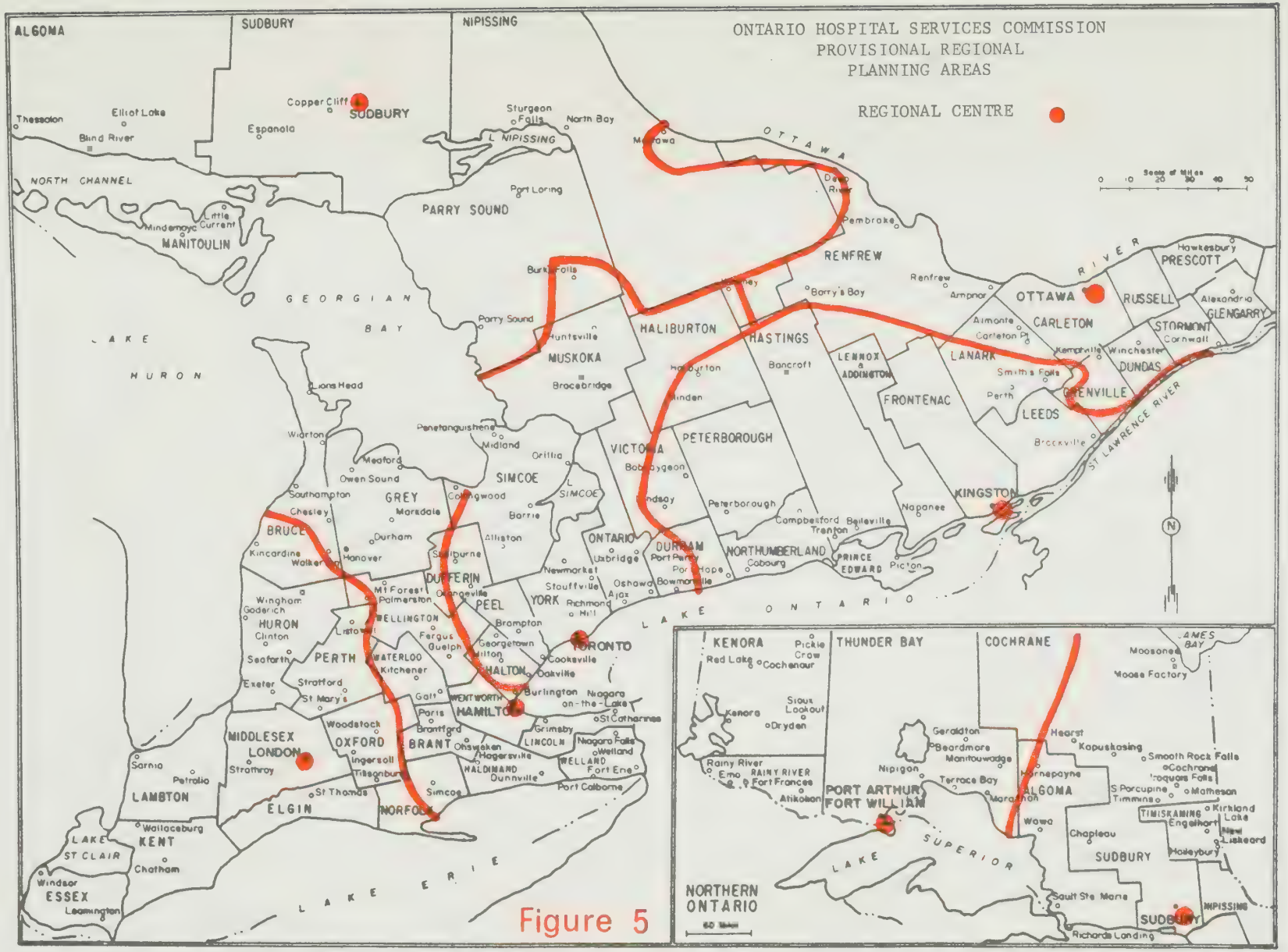
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North Bay
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Pembroke
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Little Current
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Milton
Brampton
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Oakville
Burlington
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St Catharines
Grimsby
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Welland
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Port Colborne
Dunnville
Caledonia
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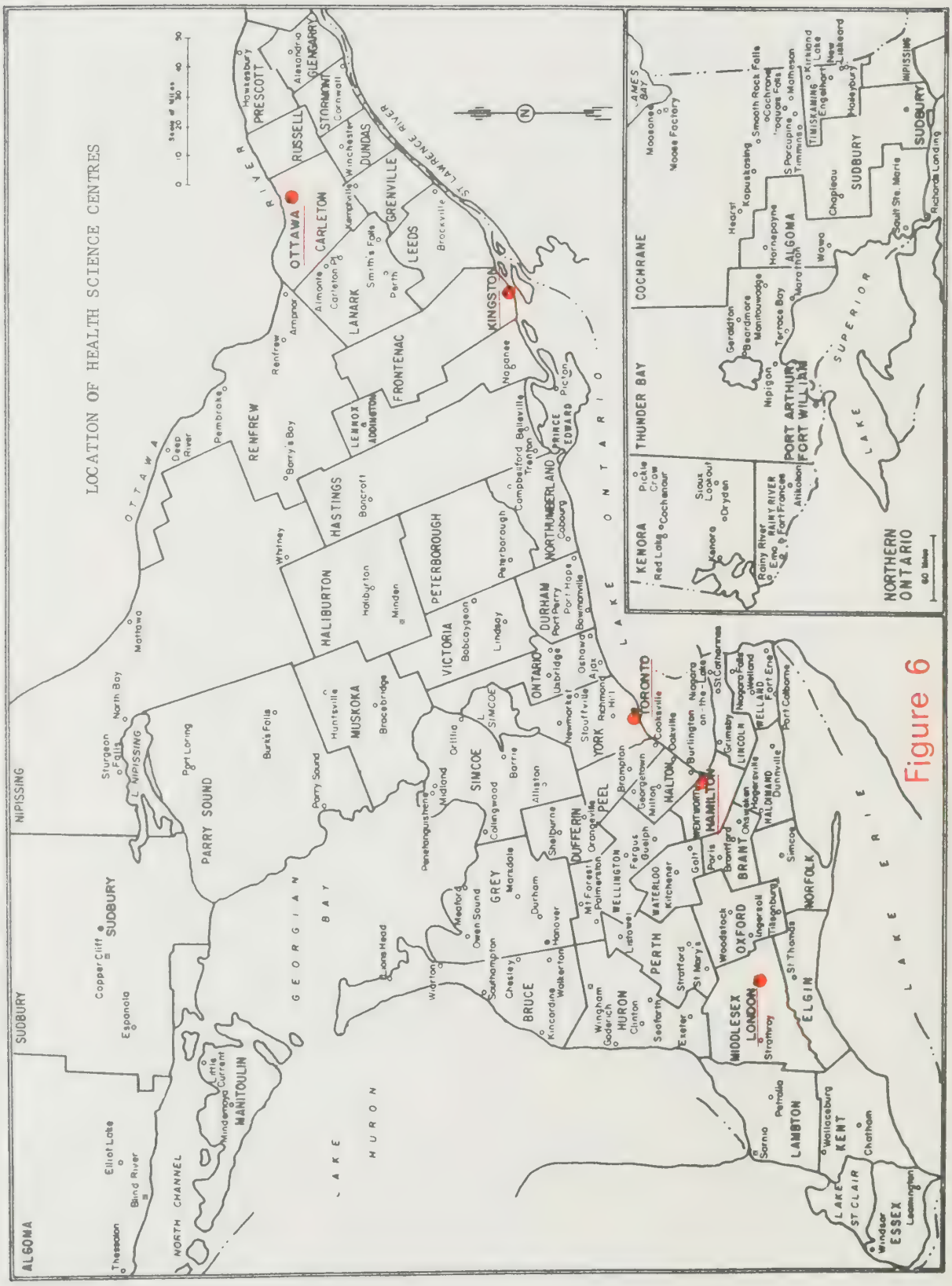
Bobcaygeon
Haliburton
Minden
Bancroft
Campbellford
Trenton
Belleville
Picton
Prince Edward
Napanee
Kingston
Brockville
Perth
Smiths Falls
Carleton Place
Almonte
Kemptville
Winchester
Cornwall
Hawkesbury
Alexandria
Ottawa
Carleton
Russell
Prescott
Glengarry
Stormont
Dundas
Grenville
Leeds
Lanark
Lennox & Addington
Frontenac
Hastings
Haliburton
Muskoka
Victoria
Peterborough
Simcoe
Grey
Bruce
Dufferin
Peel
York
Toronto
Halton
Hamilton
Wentworth
Brant
Oxford
Middlesex
London
Lambton
Kent
Elgin
Norfolk
Essex
Huron
Perth
Waterloo
Wellington
Durham
Ontario
Northumberland
Prince Edward
Scale of Miles
0 10 20 30 40 50
N
Figure 5
NORTHERN ONTARIO
KENORA
Pickle Crow
Red Lake
Cochenour
Kenora
Sioux Lookout
Dryden
Rainy River
Emo
Fort Frances
Atikokan
THUNDER BAY
Nipigon
Geraldton
Beardmore
Manitouwadge
Terrace Bay
Marathon
Port Arthur
Fort William
COCHRANE
Hearst
Kapuskasing
Smooth Rock Falls
Cochrane
Iroquois Falls
Matheson
Timmins
S Porcuping
Hornepayne
Wawa
Chapleau
Timiskaming
Englehart
Kirkland Lake
New Liskeard
Haileybury
Sudbury
Sault Ste Marie
Richards Landing
Moosonee
Moose Factory
James Bay
Algoma
Nipissing


LOCATION OF HEALTH SCIENCE CENTRES
OTTAWA
KINGSTON
TORONTO
LONDON
HAMILTON
SUDBURY
THUNDER BAY
NORTHERN ONTARIO
LAKE ONTARIO
LAKE ERIE
LAKE SUPERIOR
LAKE HURON
GEORGIAN BAY
NORTH CHANNEL
ST LAWRENCE RIVER
OTTAWA RIVER
ALGOMA
NIPISSING
PARRY SOUND
MUSKOKA
HALIBURTON
RENFREW
LANARK
FRONTENAC
LENNOX & ADDINGTON
PRINCE EDWARD
HASTINGS
PETERBOROUGH
VICTORIA
NORTHUMBERLAND
DURHAM
ONTARIO
SIMCOE
YORK
PEEL
HALTON
DUFFERIN
WELLINGTON
GREY
BRUCE
HURON
PERTH
WATERLOO
OXFORD
BRANT
NORFOLK
ELGIN
MIDDLESEX
LAMBTON
KENT
ESSEX
LAKE ST CLAIR
WELLAND
LINCOLN
HALDIMAND
RUSSELL
PRESCOTT
GLENGARRY
STORMONT
DUNDAS
GRENVILLE
LEEDS
COCHRANE
KENORA
PORT ARTHUR
FORT WILLIAM
Figure 6

Appendix B

HEALTH PROGRAMME FINANCING

APPENDIX B

Health Programme Financing

The attached three tables show the present agencies and methods involved in the financing of health care programmes.

TABLE I Indicates, for the various types of facilities and programmes in operation in the province, the agencies involved in planning, approving and funding both capital construction projects and operational expenditures.

Certain relationships and procedures have been simplified in the interests of presenting a general picture.

TABLES II AND III Show estimated commitments to capital and operating programmes for the Department of Health and for the Ontario Hospital Services Commission, and the sources of funds to meet these commitments. The Department of Health estimates are for the fiscal year ending March 31, 1969; for the O.H.S.C., capital commitments and sources are for the same fiscal year, while operating estimates and sources are for the calendar year 1969.

These tables indicate the complicated nature of the present regulations, methods and procedures for financing facilities and programmes related to health care.

With the introduction of a system of regional organization, and with the possibility of the delegation of financial authority, it is apparent that major changes in the existing financing arrangements will be necessary.

HEALTH PROGRAMME FINANCING
TABLE I – AGENCY RESPONSIBILITIES

DEFINITIONS:

Planning	The recognition of a need and the preparation of plans to meet the need.
Approval	Acceptance in principle of a programme, the detailed review of plans and actions for their implementation
Finance	The provision of funds to execute an approved programme

CODE:

P	Private
C	Local groups or boards
ADARF	Alcoholism and Drug Addiction Research Foundation
OHSC	Ontario Hospital Services Commission
D of H	Department of Health
D of PW	Department of Public Works
D of Ed	Department of Education
D of UA	Department of University Affairs
D of SFS	Department of Social and Family Services
Fed	Federal Government

Item No.	FACILITY OF PROGRAMME	CAPITAL CONSTRUCTION			OPERATING			COMMENTS
		Planning	Approval	Finance	Planning	Approval	Finance	
1	**PUBLIC FACILITIES** General hospitals (including active and/or convalescent and/or chronic, and out-patient facilities)	C	OHSC	OHSC 2/3 C 1/3	C	OHSC	OHSC C	**Capital.** The O H S C 2/3 consists primarily of Provincial monies (grant plus loan) but also includes a small and variable amount of Federal money. **Operating:** O.H.S.C involvement is through cost review of operating budgets and of actual expenditures, community involvement includes costs not met through O.H.S.C. -e.g. non-allowable costs, non-approved costs, self pay, Workmen's Compensation Board, etc. Salaries for radiologists and pathologists are allowable costs and are included in the hospital budget.
2	General hospitals as above but including, in addition psychiatric in- and out-patient facilities.	C	D of H OHSC	OHSC 2/3 C 1/3	C	OHSC D of H	OHSC C D of H	**Capital** Same as Item 1 except for Department of Health involvement **Operating** Same as Item 1, but in addition the monies required to reimburse the hospital for medical salaries relating to psychiatric out-patient services are provided by the Department of Health through the O.H.S.C., and are incorporated into the hospital budget.
3	Red Cross out-post hospitals.	BASICALLY THE SAME AS ITEM 1						**Capital.** The Canadian Red Cross Society assumes responsibility for a portion of the Community's share **Operating:** Same as Item 1
4	Public hospitals for psychiatric illness (only Clarke Institute).	D of H	D of H	D of H		D of H	D of H through OHSC	**Operating** Payment is made through the O H.S C and charged to the Department of Health
5	Public hospitals for alcoholism and drug addiction (only Donwood Foundation).	C	OHSC	OHSC 2/3 C 1/3	C	OHSC	OHSC	
6	General hospitals teaching, (including research facilities, and regional rehabilitation centres)	University C	Senior Co-ordinating Committee OHSC	OHSC FED	University C	OHSC	OHSC University C	**Capital** The Senior Co-ordinating Committee consists of representatives of the Department of Health and University Affairs and of O H S C This Committee is responsible for the educational and research aspects. The facilities for teaching are financed 100 - through the O H S C and the Federal Government Financing of other construction and renovations is O.H.S.C. 2/3, Community 1/3, except for University (on campus) hospitals where it is 100% O.H.S.C. and the Federal Government. **Operating:** Same as Item 1

TABLE I continued

Item No.	FACILITY OF PROGRAMME	CAPITAL CONSTRUCTION			OPERATING			COMMENTS
		Planning	Approval	Finance	Planning	Approval	Finance	
7	Community psychiatric hospitals (6 hospitals, e g Royal Ottawa Sanatorium psychiatric hospital)	C	D of H	D of H FED	C	D of H	D of H through OHSC C	Capital New construction in a Community Psychiatric Hospital is supported by a grant of a fixed amount per bed and per unit of floor space The Regulations in force provide Provincial Grants of $8,500 per bed, and $3,200 per 300 square feet of floor space or the actual cost, whichever is lesser. The Federal Grants of $2,000 per bed and $2,000 per 300 square feet of floor space are additional to the Provincial Grants. The Grants provided for renovation projects are on the same basis but at a lower level, viz., $3,000 per bed and per 300 square feet of floor space. Here again, Federal Grants provide an additional $2,000 per bed, and $2,000 per 300 square feet of floor space, providing the total Federal and Provincial Grant does not exceed the actual cost. Operating: The Department of Health is responsible for the net allowable operating costs of both in-patient and out-patient services provided by Community Psychiatric Hospitals. This assistance is paid through the Ontario Hospital Services Commission on the basis of an annual budget, subject to prior approval and year end audit and adjustment.
8	Tuberculosis sanatoria (12 sanatoria).	C	D of H		C	D of H	D of H C	
9	Alcoholism and Drug Addiction Research Foundation facilities	ADARF		D of PW	ADARF	D of H ADARF		
10	**PROVINCIAL FACILITIES** Psychiatric hospitals (including regional and special hospitals and residential units) (16 hospitals—formerly called Ontario Hospitals).	D of H	D of H	D of PW	D of H	D of H	D of H	Capital Subject to overall Provincial government priorities
11	Regional hospital schools and specialized training facilities (9 facilities—e g Smiths Falls Hospital School, and Edgar Adult Occupational Centre).	D of H D of Ed	D of H	D of PW	D of H D of Ed	D of H D of Ed	D of H D of Ed	Capital: Same as Item 10. Operating. Educational programmes are staffed and operated by the Department of Education
12	Regional Centres for children (8 centres).	D of H	D of H	D of H	D of H	D of H	D of H	
13	**FEDERAL FACILITIES** Active and chronic hospitals (13 hospitals—e.g. London Westminster).	FED	FED	FED	FED	FED OHSC	FED OHSC	Operating. O H S C payment is made on the basis of a mutually agreed upon per diem rate
14	Psychiatric unit (London Westminster, psychiatric wing only)	FED	FED	FED	FED	FED OHSC	FED D of H	

TABLE I continued

Item No.	FACILITY OF PROGRAMME	CAPITAL CONSTRUCTION			OPERATING			COMMENTS
		Planning	Approval	Finance	Planning	Approval	Finance	
15	**PRIVATE CONTRACT FACILITIES** Active and chronic (43 hospitals, e.g. Toronto Doctors Hospital, Thorold–Maplehurst).	P	OHSC	P	P	OHSC	OHSC P	**Operating** From a cost review of operating budgets, a per diem rate is established which may be adjusted after a year end audit. This rate includes (a) depreciation on the physical plant based on the Canadian Hospital Accounting Manual or Income Tax Schedules, (b) return on investment at 6½%, (c) interest on debt.
16	Institutions for Nervous Ailments (13 facilities, e.g. Waterloo–Sunbeam Home; Brantford Sanatorium–Annex; Kingston–Institute of Psychotherapy)	P	D of H	P	P	D of H OHSC	D of H through OHSC	**Capital:** Special grants may be provided through an accountable warrant **Operating:** Two methods of financing are used – (a) Same as Item 15. (b) For some facilities, financial assistance is provided on the basis of an annual budget, subject to prior approval, year end audit and adjustment. In both instances, payment is made through the O.H.S.C. and charged to the Department of Health
17	**MISCELLANEOUS FACILITIES AND PROGRAMMES** Temporarily Approved Nursing Homes (29 homes).	P	OHSC	P	P	OHSC	OHSC	**Capital:** Approved temporarily by O.H.S.C. for the provision of chronic care. **Operating** Payment for the provision of care to chronically ill patients is made on the basis of $8.50 per patient day.
18	Approved nursing homes and residential homes (for patients not yet discharged from Provincial Mental facilities who are being rehabilitated back into the community) (177 facilities).	P	D of H	P	P	D of H	D of H P	**Operating** Payment for the provision of care is made on the basis of $8.50 per patient day in nursing homes, and $4.00 per patient day in residential homes.
19	Homes for Special Care (for patients discharged from the Provincial mental hospital system who need sheltered care) (255 nursing homes, 198 residential homes).	P	D of H	P	P	D of H	D of H P	**Operating.** Both nursing homes and residential homes are included in this programme. Payment for operations is the same as under Item 18.
20	Nursing homes (470 including the 255 nursing homes in the Homes for Special Care Programme).	P	D of H	P	P	D of H	D of SFS Individual P	**Operating:** Care for the recipients of public assistance is subsidized at the rate of $8.50 per day of care, by Department of Social and Family Services.
21	Local public health facilities (Public health unit)	C	D of H	D of H 2/3 C 1/3	C	D of H	D of H C	**Operating:** Health District – Department of Health pays 75% of cost, Health Unit – Department of Health pays 50% of cost, Municipal Health District – Department of Health pays 25% of cost in each instance municipalities pay remainder of cost

TABLE I continued

Item No.	FACILITY OF PROGRAMME	CAPITAL CONSTRUCTION			OPERATING			COMMENTS
		Planning	Approval	Finance	Planning	Approval	Finance	
22	Rehabilitation Facilities (non-public hospital) (facilities for ambulatory patients).	C	D of H	D of H 2/3 C 1/3	C	OHSC	OHSC	**Operating.** Budgets are reviewed with the assistance of the Department of Health and payments are made by OHSC for this insured service.
23	Home Care Programme	N/A	N/A	N/A	C	D of H OHSC	D of H OHSC	**Operating:** An Interdepartmental Committee comprised of representatives of O.H.S.C. and Department of Health reviews and approves local programmes and budgets. Half of the cost is borne by the Department of Health, and half is met by O.H.S.C.; payment is made through O.H.S.C.
24	Approved physiotherapy facilities for office and home treatment.	P	OHSC	P	P	OHSC	OHSC	**Operating:** Payment is made on the basis of $3.50 per visit
25	Provincial Laboratories	D of H	D of H	D of PW	D of H	D of H	D of H	
26	Ambulance Services	C & P	OHSC	OHSC	OHSC	OHSC	OHSC Individual	**Operating** The amount charged depends on the distance travelled, charges are not to exceed $25.00 for each patient carried in the same ambulance for the first 25 miles, and an additional 60¢ per mile beyond the first 25 miles. Charges to non-insured individuals are at the same rate.
27	Education Facilities (Nursing Schools, and schools for other allied health personnel).	Hospital University C	OHSC	OHSC C	Hospital	OHSC	OHSC	

HEALTH PROGRAMME FINANCING
TABLE II – ONTARIO HOSPITAL SERVICES COMMISSION

Item Number Of Facility From Table I In This Category	PROGRAMME COMMITMENTS			SOURCES OF FUNDS		
	I Capital Costs (for the fiscal year 1968-69)			**I Capital** (for the fiscal year 1968-69)		
1, 2, 3, 5, 6	(a) Public hospitals including psychiatric and out-patient facilities (including loan monies)			(a) Treasury through O.H.S.C. (including loan monies)	$ 69,000,000	
				(b) Federal Government	12,000,000	
	TOTAL		$ 81,000,000 (1)	TOTAL		$ 81,000,000
	II Operating Costs (for the calendar year 1969)			**II Operating** (for the calendar year 1969)		
1, 2, 3, 5, 6	(a) Public hospitals including psychiatric and out-patient facilities	$638,870,000		(a) Treasury through O.H.S.C.	95,691,000	
13, 15, 17	(b) Private and federal hospitals and temporarily approved nursing homes	18,185,000		(b) Premiums	275,322,000 (4)	
24	(c) Private physiotherapy	4,025,000		(c) Federal	319,571,000	
22	(d) Rehabilitation (non-public hospital)	1,840,000		(d) Municipal	2,000,000	
23	(e) Home care	5,650,000 (2)		(e) Interest	800,000	
26	(f) Ambulance	12,020,000				
	(g) Payments provided for care outside Ontario	7,044,000				
	(h) Administration	5,750,000				
	TOTAL		$693,384,000 (3)	TOTAL		$693,384,000
	GRAND TOTAL		$774,384,000	**GRAND TOTAL**		$774,384,000

(1) The total capital cost represents the net cost to the Provincial and Federal Governments. In addition, some $20,000,000 is raised locally.

(2) Total estimated cost of the programme. Costs are shared on a 50-50 basis with the Department of Health.

(3) The total operating cost shown represents the net cost to O.H.S.C. In addition, some $160,000,000 is expended by hospitals and other agencies in providing care within the O.H.S.C. programme.

(4) Excludes premium monies ($5,000,000) designated to meet a part of the operating costs of mental health programmes administered by the Department of Health.

HEALTH PROGRAMME FINANCING

TABLE III – DEPARTMENT OF HEALTH
(for the year ending March 31, 1969)

Item Number Of Facility From Table I In This Category	PROGRAMME COMMITMENTS			SOURCES OF FUNDS		
	I Capital Costs			**I Capital**		
	(a) **Mental Health Division**			(a) Treasury through Department of Public Works	$ 8,190,000 (7)	
10, 11, 12	i. Provincial psychiatric hospitals and schools	$ 8,190,000 (1)				
7	ii. Community psychiatric hospitals	500,000		(b) Treasury through Department of Health	1,800,000 (8)	
4	iii. Institutions for nervous ailments					
	(b) **Public Health Division**			(c) Federal Government		
21	i. Local health services	1,300,000 (2)				
22	ii. Community health facilities					
	TOTAL		$ 9,990,000	TOTAL		$ 9,990,000
	II Operating Costs			**II Operating**		
	(a) **Departmental and Financial and Administrative Services Division**	16,867,000		(a) **Department of Health excluding OMSID**		
	(b) **Mental Health Division**			i. Treasury through Department of Health	196,656,000 (9)	
10, 11, 12	i. Provincial psychiatric hospitals and schools	108,222,000				
7	ii. Community psychiatric hospitals			(b) **Ontario Medical Services Insurance Division**		
4, 14, 16	iii. Institutions for nervous ailments	14,125,000 (3)		i. Treasury through Department of Health.	40,698,000	
	iv. Administrative costs	1,303,000				
	(c) **Public Health Division**			ii. Premiums	61,793,000	
21	i. Local health services	13,250,000 (4)				
19	ii. Aid re: homes for special care	12,100,000				
8	iii. Grants to sanatoria	4,400,000				
23	iv. Home Care programme	– (5)				
	v. Grants to hospital laboratories	165,000				
	vi. Administrative and miscellaneous costs	18,191,000 (6)				
	(d) **Health Insurance Registration Board**	8,033,000				
	(e) **Medical Services Insurance Division**	102,491,000				
	TOTAL		$299,147,000	TOTAL		$299,147,000
	GRAND TOTAL		**$309,137,000**	**GRAND TOTAL**		**$309,137,000**

(1) Department of Public Works construction and financing.
(2) Community health facilities can include public health unit buildings, non-hospital rehabilitation centres, medical offices, etc.
(3) The Clarke Institute is included.
(4) Grants to official local health agencies, and for school dental services. In addition, local health agencies' share of the total cost approximates $10,000,000.
(5) The Department of Health and the Hospital Services Commission share home care programme costs on a 50-50 basis. The 1969 total cost estimate is $5,650,000; this is included with the O.H.S.C. statement.
(6) Examples of miscellaneous costs are grants to voluntary organizations such as the Society for Crippled Children, convalescent summer camps and Canadian Mothercraft Centre, and direct services such as air pollution control.
(7) Included is $790,000 in maintenance expenditure by the Department of Public Works.
(8) Although the Province qualifies for Federal hospital construction grants, no disbursements have been made in recent years.
(9) Offsetting revenues and reimbursements are received from the Federal Government and other sources, totalling $32,333,000; these go into general Provincial revenues.